August 20, 2021

Edmund C. Baird
Associate Solicitor of Labor for
Occupational Safety and Health
Office of the Solicitor
US Department of Labor

RE: Docket No. OSHA-2020-0004 Occupational Exposure to COVID-19: Emergency Temporary Standard

Dear Mr. Baird:

LeadingAge appreciates the opportunity to comment on the OSHA-2020-0004 *Occupational Exposure to COVID-19; Emergency Temporary Standard* (OSHA ETS).

About LeadingAge: We represent more than 5,000 aging-focused organizations that touch millions of lives every day. Alongside our members and 38 state partners, we address critical issues by blending applied research, advocacy, education, and community-building. We bring together the most inventive minds in our field to support older adults as they age wherever they call home. We make America a better place to grow old. For more information: www.leadingage.org.

Overview

We applaud the continued efforts of the Department of Labor (DOL) and the Occupational Safety and Health Administration (OSHA) to ensure and enhance workplace safety for our country's workers, especially during this pandemic. Our members work tirelessly every day to provide a safe environment for their staff and the older adults they serve.

The promulgation of the OSHA ETS for healthcare employers misses the mark, however, as it duplicates or conflicts with existing federal, state, and local guidance, places burdensome financial consequences on healthcare employers, and is simply not feasible in many circumstances for long-term care providers.

Below we outline our concerns and comments on the OSHA ETS. LeadingAge previously wrote to OSHA requesting a six-month delay of the enforcement of the OSHA ETS requirements as well as an additional 30 days to submit comments. We thank OSHA for granting an additional 30 days to comment, but reiterate our request to delay enforcement of the ETS requirements based on the comments below.

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The Implementation Timeframe for the ETS is Unrealistic and Enforcement Should be Delayed

The ETS was published in the federal register on June 21, 2021, with the implementation date for most provisions on July 6, 2021. A two-week turnaround time (which included a July 4th holiday weekend) to analyze and implement a substantial new workplace rule proved unworkable. Although OSHA provided numerous materials on their website to assist employers to comply with the ETS, some providers continue to struggle with how to specifically implement the requirements within their organizations and in their various care settings. Part of this struggle lies with the conflicting and confusing regulatory requirements of the OSHA ETS and the existing and evolving guidance from the Centers for Disease Control and Prevention (CDS), Centers for Medicare and Medicaid Services (CMS), and other state and local governments.

Moreover, as with most significant regulatory changes, questions arise that are not addressed directly in the regulations. Without any additional guidance from OSHA on how to interpret many of the regulatory provisions, providers are stressed with compliance while at the same time worried about enforcement and potential penalties. It goes without saying, that this is all happening in the midst of a continuing pandemic where long-term care providers continue to be on the front lines of stopping the spread of COVID-19 and caring for those that become infected.

This is especially difficult for rural providers and other smaller organizations that lack the resources and staff in normal times and it is only exacerbated now. Setting up barriers is just one example of a burdensome and time-consuming exercise, especially when the OSHA requirements may differ from the CDC guidance that is changing based on the current conditions and data. The notification provisions are another difficult area of concern as some information is not readily available to providers to comply within the short 24-hour timeframe.

Long-term care providers across the continuum of care, as well as other healthcare entities, need time to thoughtfully implement the ETS requirements based on what they are already doing under the various existing guidance and regulations and the new requirements of the ETS. Therefore, enforcement of the OSHA ETS should be delayed to allow healthcare providers time to comply with the requirements of the ETS.

OSHA Should Use Discretion to Recognize Good Faith Efforts to Meet ETS Requirements

As noted in the ETS, OSHA inspectors and agency staff have discretion to recognize good faith efforts toward meeting the standards promulgated in the ETS. OSHA should make good on those words and allow flexibility beyond the compliance deadlines and refrain from instituting costly fines as long as a provider is working towards implementation of the OSHA ETS requirements.

Providers would also welcome additional guidance and clarification to assist them in implementing ETS requirements, including such options as telephone or email support or consultations with OSHA staff to answer questions without fear of reprisals. Such efforts would

go a long way in ensuring a safe and healthy workplace for staff. Further, we recommend that inspectors be given guidance to focus on education rather than imposing penalties when assessing compliance with the new requirements, especially if there is a good faith effort by the provider.

OSHA should also recognize situations where compliance with some of the ETS requirements is simply not feasible for long-term care providers, but they have nonetheless used good faith efforts to comply. For example, the ETS requires notification of COVID-19 exposure to employees and other employers within 24 hours. These notifications, however, cannot include the employee's name, contact information, or occupation. Long-term care providers often have contract or agency staff working on site as well as visitors within their communities. They may not have contact information for all employees and individuals or be aware of any other employers they may be working for. Thus, notifying any employee and other employers of potential exposure within 24 hours may not always be possible. OSHA should recognize provider good faith efforts to comply with the ETS requirements in these situations and others.

Existing Federal and State Requirements are Sufficient to Ensure Workplace Safety

Guidance and recommendations from the CDC (and corresponding CMS guidance for nursing homes and some other healthcare entities) have been the standard for safety throughout the COVID-19 pandemic. CMS has held certain healthcare and long-term care providers accountable to comply with the CDC guidance. Alignment and consistency between the CDC standards, CMS requirements, and OSHA standards is critical to create more certainty on the best ways to protect staff, residents, and visitors. This also assures that the guidance and requirements are in line with the evolving science and literature. CDC and CMS have worked tirelessly to be on the same page to issue consistent guidance and regulations. However, some requirements in the ETS conflict with current CDC and CMS guidance, thus confusing healthcare providers and creating an unreasonable burden to comply with the ETS requirements while trying to follow the other existing guidance.

At several points throughout the ETS, OSHA notes CDC infection control or clinical guidance like personal protective equipment (PPE) requirements for aerosol generating procedures, exceptions for vaccinated employees, listing symptoms of COVID-19, and removal from work criteria. Despite these references, there are several inconsistencies between the OSHA ETS, CDC guidance, and state or local requirements. Moreover, CDC guidance changes based on new data as the science evolves, which will likely introduce more inconsistencies and/or render the OSHA ETS standards out of date soon. These inconsistencies breed confusion and additional burden on providers to analyze all the sets of guidance and when in conflict, pick which one to comply with and by necessity making them not in compliance with the other guidance. This is neither an ideal way to run a business nor a reasonable way to operate and protect vulnerable adults and staff members.

OSHA already has ways to investigate and enforce workplace safety concerns during the pandemic through the COVID-19 National Emphasis Program (NEP) and the general duty clause

of the OSH Act of 1970. CMS and state agencies have the authority to survey and enforce existing federal and state regulations, which include most of the items contained in the OSHA ETS. There are existing mechanisms to protect workers in healthcare workplaces and the OSHA ETS adds additional, unnecessary burdens without adding any meaningful worker protections. Therefore, we recommend that OSHA rescind the ETS so healthcare providers can focus on the existing and sufficient federal and state guidance. OSHA retains the ability under the COVID-19 NEP and the enforcement of the general duty clause to ensure safe workplaces. It had done so for over a year at the beginning of the pandemic.

The OSHA ETS Should Fully Incorporate CDC Guidance

If OSHA does not rescind the ETS, it should really focus on one clinical standard or guidance to follow to avoid confusion for providers. As noted previously, the discrepancies between the OSHA ETS and the other guidance from CDC, CMS, and state agencies leaves providers in an impossible spot to choose which regulation to comply with. CDC and CMS have the clinical expertise that is appropriate under the current circumstances and OSHA should defer to their judgment. This would eliminate the confusion and time-consuming efforts to sort out what guidance applies and how it applies. It cannot be understated how frustrating and burdensome it is for providers to sort out conflicting sets of guidance and recommendations. There should be one set of guidance and it should be the CDC guidance.

Also, the ETS as drafted does not allow for flexibility for those states and communities with low community infection rates. Requiring full screening of every person and additional structural and cleaning guidelines are particularly difficult for in organizations in areas with low community infection rates that are already experiencing significant workforce shortages and lack of resources. The CDC guidance allows flexibility in areas with low community infection rates, but the OSHA ETS is not as nimble to address the existing and changing situations in communities across the country. This is another reason OHSA should focus on one source of recommendations – from the CDC.

The Medical Removal Provisions are Costly, Confusing, and Outside the Jurisdiction of OSHA

Many employers have been subject to the expanded mandatory and/or voluntary employee leave provisions passed by Congress during the pandemic under the Families First Coronavirus Response Act (FFCRA) and the American Rescue Plan Act of 2021. The mandatory leave provisions expired at the end of 2020, around the same time that COVID-19 vaccines became available for residents and staff. The voluntary leave provisions and associated tax-credits expire next month.

Now, with the medical removal provisions in the ETS, healthcare providers are forced to subsidize the risk of those employees that choose to not get vaccinated by paying benefits to employees who contract COVID-19, regardless of where they were exposed. In addition, this does not encourage vaccination, but rather reinforces the decision to not get vaccinated. Long-term care providers have been on the front lines of the pandemic and have been greatly

impacted by such leave provisions. The medical removal provisions are also not clear regarding repeat COVID-19 infections, those suffering from “long-haul” COVID-19, and when the benefits may expire.

Finally, and most importantly, this medical removal provision is primarily a compensation and benefit matter, which falls outside OSHA’s authority in promulgating the ETS.

The Cost Estimates in the ETS are Not Realistic

With the limited time to comment on the ETS, LeadingAge has not been able to compile a thorough data set but we believe that the cost estimates contained in the ETS are low. Providers have seen dramatically increased costs during the pandemic to address PPE, screening and monitoring, barriers, cleaning, infection control, increased labor costs, and more. We have observed that these costs have consistently been significantly more than anticipated based on the shortage of supplies and workforce challenges, as well as the time it takes to implement and revise policies to comply with the changing guidance.

The OSHA ETS requirements raise similar concerns. We know that compliance costs and costs for equipment, supplies, and PPE have increased dramatically so we know that the estimates in the ETS are low, especially considering the time and effort to comply with the ETS especially while analyzing the differences with existing CDC, CMS, and state guidance. We will forward to OSHA any updated data to support our conclusions as it becomes available.

The ETS Should Not Be Made Permanent

Finally, since the beginning of the pandemic, long-term care providers have followed the numerous and evolving guidance and requirements from CMS and CDC – all of which are aimed at preventing the spread of COVID-19. These efforts include such items as infection control measures such as symptom screening, routine testing, cleaning, and PPE. Long-term care communities have implemented most of the requirements identified in the OSHA ETS to protect their staff and residents based on the guidance from other government entities. The burden for providers in having to follow similar but different guidance from multiple agencies is significant and adds a layer of confusion as well as interferes with the abilities of professionals to make good, clinical decisions.

Therefore, we also oppose OSHA making the ETS a permanent standard. As noted above, there are already *many* requirements and regulatory provisions in place by the CDC and CMS as well as state and local governments to adequately ensure a safe workplace.

Closing

In closing, although the OSHA ETS is well-intended, it is unnecessary and overly burdensome as there are existing federal, state, and local regulatory and statutory frameworks that adequately address workplace and resident safety. The additional burdens placed on health care providers

in the ETS, especially long-term care providers, are counterproductive to achieving a robust and safe healthcare sector and the goal of getting more workers vaccinated to stop the spread of COVID-19. We all desire a safe workplace and want the COVID-19 pandemic to subside, but unfortunately the OHSA ETS is not a suitable tool to help achieve those goals.

LeadingAge appreciates your time and attention to these issues. Should you wish to discuss these concerns further or have any questions, please contact Cory Kallheim ckallheim@leadingage.org. We value OSHA's commitment to workplace safety and look forward to continued work together to ensure a quality workplace and home for older adults.

Sincerely,

Cory Kallheim
VP, Legal Affairs and Social Accountability
LeadingAge

August 19, 2021

VIA ELECTRONIC SUBMISSION

Edmund C. Baird
Associate Solicitor of Labor for Occupational Safety and Health
Office of the Solicitor
U.S. Department of Labor
Attention: OSHA-2020-0004

RE: Occupational Exposure to COVID-19; Emergency Temporary Standard (OSHA-2020-0004)

Dear Mr. Baird:

On behalf of our members, Argentum appreciates this opportunity to provide comments on the Occupational Exposure to COVID-19 Emergency Temporary Standard (ETS).[1] Argentum is the leading national association exclusively dedicated to supporting companies operating professionally managed, resident-centered senior living communities and the older adults and families they serve. Along with its state partners, Argentum's membership represents approximately 75 percent of the professionally managed communities in the senior and assisted living industry. Nearly one million older adults live in an estimated 28,000 assisted living facilities (ALFs) across the United States.

Despite being home to a highly vulnerable population to COVID-19, with an average resident age of 85, ALFs have had comparatively favorable outcomes in caring for this at-risk population. According to a survey from NORC at the University of Chicago, two-thirds of ALFs had no COVID-19 related fatalities and the fatality rate in ALFs was 1/3 of skilled nursing care facilities (SNFs) (19.3 fatalities per 1,000 residents in assisted living, compared to 59.6 per 1,000 in SNFs). Notably, these results are reflective of calendar year 2020, largely before vaccines became available to further protect residents and staff.

Vaccines are perhaps the most critical element in guarding against the virus, and ALFs have led efforts to vaccinate both residents and staff, with overall vaccination rates higher than 99% of all U.S. counties. A relatively high percentage of ALFs participated in the Pharmacy Partnerships program, leading to over 90% of residents and more than 7 out of 10 workers being vaccinated.[2] The high vaccination rates are a key metric, as the Centers for Disease Control and Prevention (CDC) estimates that less than 0.004 percent of people fully vaccinated in the United States face hospitalization after a breakthrough case and less than 0.001 percent have died from a breakthrough COVID-19 case.

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[1] 86 Fed. Reg. 32376 (June 21, 2021).
[2] *See* National Investment Center for Seniors Housing & Care, *Executive Survey Insights Wave 29: May 17 to June 13, 2021* (June 24, 2021), https://blog.nic.org/executive-survey-insights-wave-29-. (finding vaccination rates at long-term care facilities to be 9 out of 10 for residents, and 2 out of 3 for staff).

Additionally, it is important to recognize that unlike SNFs, ALFs provide only limited "healthcare services" (defined in part as services provided by "doctors and nurses"), and instead primarily assist residents with basic self-care or activities of daily living (ADLs) such as eating, dressing, bathing, and the management or administration of medication. Assisted living facilities are also a lower-risk environment than "hospital ambulatory care settings" and "non-hospital ambulatory care settings," which are exempt from this ETS in certain circumstances.

As explained in further detail below, we believe that this ETS should not be made permanent because it is: 1) duplicative of and at times conflicts with CDC-specific guidance and state-level regulations for long-term care facilities and assisted living facilities in particular; 2) overly burdensome on ALFs, many of which are experiencing severe financial difficulty as a result of the COVID-19 pandemic; 3) unnecessary given the assisted living community's substantial compliance with all relevant federal and state requirements and recommendations regarding COVID-19 infection control protocols, and its overwhelming success at containing COVID-19 in ALFs; 4) adds burdensome costs on the industry in having to pay sick time for employees even if their exposure was outside of work; 5) the sick pay provision discourages vaccinations; 5) OSHA does not have the statutory authority to dictate pay and benefits rules for employees; and 6) several provisions are vague. At a minimum, if OSHA makes the ETS a permanent standard, OSHA should exercise its enforcement discretion for providers who make good faith efforts to comply with the spirit of this ETS.

<u>The OSHA ETS is duplicative of and at times conflicts with CDC-specific guidance and state-level regulations for long-term care facilities.</u>

ALFs have complied with myriad federal and state level requirements and guidance regarding infection control protocols that have protected both staff and residents. In particular, facilities throughout the country have complied with CDC guidance related to the use of personal protective equipment (PPE), social distancing, sanitation procedures and other requirements to mitigate the spread of COVID-19. ALFs also comply with additional state-level requirements. Accordingly, for over a year, facilities have implemented comprehensive infection control protocols pursuant to an existing framework established by the CDC and state level agencies such as departments of health.

State and local agencies have been very effective and proactive in providing guidance that reflects current and changing conditions in their regions and have closely monitored compliance. For the most part, the requirements set out in this ETS are duplicative of this existing framework, and only serve to add an additional layer of unnecessary complexity and confusion for facilities that have successfully implemented the existing framework to curb the spread of COVID-19 in their facilities, which have been tailored to regional and locality conditions. This framework also allows necessary flexibility based on the current conditions in a particular area, rather than a one-size-fits-all approach from federal OSHA. And with duplicative or contradictory guidance, employers would be forced to determine which set of guidance to follow, potentially leading to reputational harm if penalized for not adhering to guidance that may no longer be in line with current best practices.

Notably, ALFs were already subject to infection prevention and control training requirements even prior to COVID-19. As a result of the pandemic, additional training was imposed by state

regulators—including agencies that do not typically regulate ALFs—along with local or county departments of health. These duplicative layers of training and attendant paperwork create administrative burdens and divert important and increasingly scarce resources away from resident care, which would be further exacerbated by this ETS.

An example of the inconsistencies between the ETS and other guidance is that the ETS exempts fully vaccinated employees from wearing facemasks or maintaining physical distance from others "[i]n well-defined areas where there is no reasonable expectation that any person with suspected or confirmed COVID-19 will be present." 29 C.F.R. § 1910.502(a)(4). In contrast, on July 27, 2021, the CDC recommended that all employees wear facemasks in indoor public settings in areas with substantial or high transmission of COVID-19, including all vaccinated individuals. On August 13, 2021, OSHA made the same recommendation. The ETS does not, however, include a requirement or recommendation to do the same. Thus, in that aspect, the ETS is less protective than OSHA guidance for non-healthcare workplaces. A static or slow-changing ETS will continually fall out of step from the developing science and best practices as the CDC continues to update its guidance.

The OSHA ETS's additional requirements and penalty framework are overly burdensome for long-term care facilities already under significant financial strain due to the COVID-19 pandemic and add duplicative expenses for seniors already under pressure to cover costs of living.

The ETS is a comprehensive and complex set of requirements that will require a significant amount of time and resources to review and ensure compliance. It contains references to many external sources and expects employers to both analyze those sources and determine which provisions are applicable. We are concerned that implementing an additional infection control regime will be overly burdensome for long term care providers and seniors and may ultimately divert time and resources away from resident care.

For example, the ETS requires removal of employees from the workplace who have tested positive for COVID-19, been told by their healthcare provider that they are suspected to have COVID-19 or is experiencing an elevated temperature, loss of taste or loss of smell. Included in this requirement is a complex timeline of monitoring and testing, most of which providers are already accomplishing through adherence to CDC guidelines and state regulations. The ETS then requires the employer to continue to pay these employee's normal earnings up to $1,400 a week for the first two weeks and the same or slightly reduced amount thereafter. This requirement can be overly burdensome for many providers that have already extended significant amount of paid leave throughout the pandemic, and that are already experiencing a significant workforce shortage. Notably, there is no maximum duration on the length of medical removal, meaning an employer's obligations to provide paid leave and to reinstate the employee are indefinite and may hit an ALF particularly hard if they must continue regular pay for an individual experiencing "Long COVID" while also paying for temporary workers.

Similarly, it is unclear how long an employer must provide paid leave for adverse effects associated with vaccination. OSHA does not have the necessary personnel, and its compliance safety and health officers may lack experience or resources to properly audit payroll records by individual employee to determine compliance with the requirement to provide continued

benefits and regular pay during medical removal periods. Finally, the "regular pay" requirement is unworkably vague, as it does not clarify other types of permissible employer-funded compensation, such as paid time off.

Many obligations related to paid leave are vague and ambiguous. The ETS requires employers to pay the "same regular pay and benefits the employee would have received had the employee not been absent from work." Although the preamble to the Final Rule states that employers are not required to provide "overtime pay," the standard makes no reference to overtime. It is unclear whether employers are obligated to pay straight time wages for all hours that would have been worked, or to pay only up to 40 hours per week. The ETS does not explain what is encompassed in "benefits" (i.e., health care, accrual of paid leave, etc.). It also fails to provide any guidance on how employers should compensate employees with irregular schedules.

We are also concerned that this requirement may incentivize employees to *not* get vaccinated – which undermines the national campaign surrounding the most effective way to curb the spread of COVID-19. The prospect of being forced to take unpaid leave due to COVID-19 infection or exposure might encourage some employees to get vaccinated. This requirement undermines that sentiment by ensuring employees have a steady stream of income if they are medically removed. At this stage of the pandemic, COVID-19 vaccines are readily available, and our members have implemented a variety of programs to encourage their employees to get vaccinated. We do not believe a paid leave policy that incentivizes employees to refuse the vaccine should be finalized or made permanent.

Furthermore, we are deeply concerned with the requirement that barriers be installed at each fixed work location outside of direct patient care areas where each employee is not separated from all other people by at least six feet of distance. According to OSHA, fixed locations where barriers may be required include entryways, lobbies, check-in desks, screening sites, and security guard stations. While we understand that physical barriers may provide some benefit in reducing COVID-19 spread, we believe this requirement is overly burdensome for many providers, as well as unnecessary considering other risk mitigation strategies already in place. Moreover, this requirement disregards the fact that our members' residents consider these facilities their homes. Erecting physical barriers throughout the facilities can be a cause of confusion and stress for the residents, especially those suffering from cognitive impairment.

Last, the requirement that employers must provide employees with facemasks and to ensure that employees change their facemask at least once per day is duplicative to state and local regulations already in place. Providers should not be placed in position to suffer penalty from one agency for complying with closely monitored state and local rules and inspections. The ETS' respirator requirement fails to consider ongoing respirator shortages and supply chain challenges. In particular, the requirement to provide a respirator to all employees who have exposure to a person with suspected or confirmed COVID-19 fails to include prioritized facemask use for selected activities recommended by CDC for Crisis Capacity Strategies. For example, employers facing respirator shortages must have the capacity to prioritize respiratory protection for nurses who perform aerosol-generating procedures on COVID-19 positive residents over maintenance workers who can enter a room briefly at a safe distance to empty a wastebasket.

These are just a few examples of the ETS requirements that are beyond the scope of current CDC and state-level requirements and recommendations. These requirements would be overly burdensome for ALFs that have already undergone significant financial distress due to the COVID-19 pandemic, and that have received relatively little federal support. For over a year, our member communities have been working tirelessly to keep safe and engaged the residents who call senior living home as well as the employees who tend to their personal care needs.

Despite caring for a highly vulnerable population, assisted living communities have not received anywhere near the same level of federal and state relief as other types of providers. ALFs have suffered over $30 billion in losses due to PPE, testing, cleaning, staffing needs and heroes pay, as well as record-low occupancy rates. Yet to date, assisted living caregivers have received only about $1 billion in relief from the Provider Relief Fund (PRF), which represents less than 1 percent of the overall fund. Many are still waiting for relief, and others have been inexplicably denied. As a result, nearly half are operating at a loss, and 56% report that closures are imminent.

Mandating these facilities to comply with the additional requirements laid out in the ETS will only exacerbate these concerns, especially given the penalties for noncompliance. OSHA states that the ETS will facilitate "determinations that are critical enforcement tools OSHA can use to adequately address violations…." With the ETS, OSHA seeks to utilize the "willful classification" and impose penalties of $136,532 per violation accordingly. Even violations that are not deemed "willful" can result in penalties of $13,653 per violation. Thus, many facilities that are already under significant financial strain will find it difficult to immediately comply with the ETS's comprehensive set of additional requirements, and may be subject to onerous penalties that will only make matters worse.

Long-term care facilities have successfully implemented existing infection control requirements and guidance to curb the spread of COVID-19 amongst staff and residents.

Throughout the course of the COVID-19 pandemic, the assisted living industry has complied with all relevant guidance and recommendations to keep employees and residents safe. Since the beginning of the COVID-19 pandemic in the U.S., ALFs have implemented enhanced protocols to prevent COVID-19 from entering the community, and to mitigate the spread of, and otherwise limit the harm from COVID-19. For example, properties implemented staff workflow changes and visitor restrictions to reduce disease spread.[3] Other steps have included enhanced infection control protocols; restrictions on or cessation of move-ins; conducting health screenings and COVID-19 testing as available and appropriate for employees and residents; and vaccinations administration.[4]

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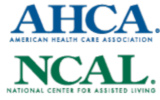
[3] A. C. Pearson et al., *The Impact of COVID-19 on Seniors Housing*, NORC at the University of Chicago (June 3, 2021), p. 18, https://info.nic.org/hubfs/Outreach/2021_NORC/20210601NICFinalReportand20ExecutiveSummary20FINAL.pdf. (hereinafter "the NORC Report").
[4] *Id*.

Argentum believes the protocols ALFs have had in place for over a year achieves the stated intent of the ETS, and that adding an additional layer of regulatory complexity on a community that has experienced severe financial distress will be to the detriment of the elderly population we are committed to serving. As such, we request that the ETS not become a final rule, and that OSHA exercise enforcement discretion for providers who make good faith efforts to comply with the general spirit of the ETS. However, if this ETS should become final, we request that assisted living providers be exempt similar to the exemptions already in place in this ETS.

Thank you for your consideration of these comments. Please contact me with any questions or requests for additional information.

Sincerely,

James Balda
President & CEO
Argentum



August 16, 2021

The Honorable James Frederick
Acting Assistant Secretary
Occupational Safety and Health Administration
U.S. Department of Labor

Docket No. OSHA-2020-0004

Dear Mr. Frederick:

The undersigned organizations represent our nation's long term and post-acute care providers who care for millions of individuals that are frail, elderly, or disabled. We appreciate the opportunity to comment on OSHA's Occupational Exposure to COVID-19; Emergency Temporary Standard (ETS) and that OSHA extended the deadline to submit comments. While each of our organizations will be submitting individual comments, we are writing to you collectively on our opposition to the ETS being potentially converted into a permanent standard.

COVID-19 has created -- and continues to create with the Delta variant -- unprecedented challenges for our entire health care and public health system. With the population that we serve, there is no doubt that long term care (LTC) communities have been at the forefront of this pandemic. Each of our organizations remain focused on protecting the health care heroes that care for our nation's most vulnerable, and we appreciate the importance of standards that ensure the health and safety of the health care heroes who have already sacrificed so much.

Since February of 2020, LTC facilities have been adhering to numerous evolving guidance and requirements from the Centers for Medicare and Medicaid (CMS) and the Centers for Disease Prevention and Control (CDC) aimed at preventing the spread of COVID-19. This includes infection control measures such as symptom screening, routine testing, cleaning, and the use of personal protective equipment. Many of the requirements in the OSHA ETS are already in place in most LTC communities. We urge OSHA to take into consideration the burden for providers in having to follow similar but different guidance from multiple agencies. This adds a layer of confusion and interferes with the abilities of professionals to make good, clinical decisions. **To this end, we recommend that the ETS not be converted to a permanent standard as CDC, CMS and state and local government/entities already have measures in place to account for staff safety.** In addition, given the pace of vaccinations in the long term care industry and OSHA's intent to promulgate a permanent airborne infectious disease rule, continuing the ETS beyond six months is not reasonable or appropriate.

We request that OSHA work with long term care providers to develop airborne infectious disease standards that are feasible, protect employees, and can serve in various outbreaks to allow for providers to be fully prepared and supported in these efforts. Each of our organizations would be willing to work with OSHA on this and help with identifying stakeholders to participate in these efforts.

Thank you in advance for your consideration of our request. Should you have any questions around this matter, we would be happy to connect OSHA directly with some of our members to hear firsthand the impact this ETS will have on our nation's caregivers and the individuals they serve.

Regards,

Mark Parkinson
President & CEO
American Health Care Association/
National Center for Assisted Living

David Schless
President
American Seniors
Housing Association (ASHA)

James Balda
President & CEO
Argentum

Katie Smith Sloan
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LeadingAge

Patricia Budo
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Pediatric Complex Care Association